



AUBURN UNIVERSITY  
AT MONTGOMERY

STUDENT HEALTH SERVICES

P.O. Box 244023  
Montgomery, AL 36124  
Phone: 334-244-3281  
Fax: 334-244-3396

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Information

|                                    |                                                 |
|------------------------------------|-------------------------------------------------|
| Student Number: _____              |                                                 |
| Name: <u>Stephen Bicknell</u>      | Date of Birth: <u>02/23/2007</u>                |
| Address: <u>2159 County Rd. 01</u> | Phone Number: <u>(334) 540-8712</u>             |
| City: <u>Prattville</u>            | State: <u>AL</u> Zip: <u>36067</u> Email: _____ |

Please select one of the following:

- ☐ Release information FROM Auburn University at Montgomery Student Health Services to an AUM department/outside medical facility/person (Circle one)
- ☒ Release information from an AUM department/outside medical facility/person (Circle one) TO Auburn University at Montgomery Student Health Services

Outside Medical Facility/ AUM Department/Person

|                                  |                                                 |
|----------------------------------|-------------------------------------------------|
| Name: <u>Elmore Community ER</u> | Date of Birth: <u>      </u>                    |
| Address: <u>500 Hospital Dr.</u> | Phone: _____ Fax: <u>(334) 507-5919</u>         |
| City: <u>Montgomery</u>          | State: <u>AL</u> Zip: <u>36102</u> Email: _____ |

Please select one of the following:

- ☒ Fax Records ☐ Mail Records ☐ Hold Records for Patient Pickup

Type(s) of Records Requested:

- ☐ Immunizations ONLY: please specify (if all, put ALL) \_\_\_\_\_
- ☒ Radiology Report
- ☒ Lab Results
- ☒ General summary of treatment issues, progress, current functioning
- ☒ Other: please specify all records from ER visit in May 2024

This consent may be needed at any time by the patient/client, but ending the consent will not cancel any actions that have already taken as allowed by this form. Unless the client wishes to cancel this consent at an earlier time, it will automatically stop upon the date and/or condition indicated below.

Date: \_\_\_\_\_ Event/Consent: \_\_\_\_\_

It is understood that the duration of this consent will not be longer than necessary and reasonable to carry out the purpose for which it is given.

Miranda Bicknell (mom)  
Patient Name or Authorized Representative (Please Print)

0629  
Last 4 of Patient's Social Security #

[Signature]  
Patient's Signature or Authorized Representative

[Signature]  
Witness Signature (REQUIRED)

7/30/24  
Date

7/30/24  
Date